FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0036186

Facility Name: Holy Family Villa

Address: 12375 McCarthy Road, (Number) Lemont (City) 60439 (Zip Code)

County: Cook

Telephone Number: 630-2572291 **Fax #** 630-2572334

IDPA ID Number: 36-3680983

Date of Initial License for Current Owners: 1947

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501 © 3		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: William H. Brower **Telephone Number:** 630-8520334

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/99 to 6/30/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Roberta Magurany

(Title) Administrator

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) William H. Brower, CPA

(Firm Name & Address) William H. Brower, 32 W. Burlington, Westmont, IL, 60559

(Telephone) 630-8520334 Fax # 630-8521309

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Holy Family Villa # 0036186 Report Period Beginning: 7/1/99 Ending: 6/30/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	99	Intermediate (ICF)	99	36,234	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,234	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	18,000	17,444		35,444	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,000	17,444		35,444	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.82%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 1947

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 6/30/00 Fiscal Year: 6/30/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Holy Family Villa # 0036186 **Report Period Beginning:** 7/1/99 **Ending:** 6/30/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	193,600	33,916	39,450	266,966		266,966		266,966			1
2	Food Purchase		196,962		196,962		196,962		196,962			2
3	Housekeeping	150,697	16,121		166,818		166,818		166,818			3
4	Laundry	70,326	22,628		92,954		92,954		92,954			4
5	Heat and Other Utilities			92,764	92,764		92,764		92,764			5
6	Maintenance	92,777	46,132	33,042	171,951		171,951		171,951			6
7	Other (specify):*											7
8	**TOTAL General Services**	507,400	315,759	165,256	988,415		988,415		988,415			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	998,880	35,644	42,249	1,076,773		1,076,773		1,076,773			10
10a	Therapy	11,413	632		12,045		12,045		12,045			10a
11	Activities	71,500	6,658	13,490	91,648		91,648		91,648			11
12	Social Services	79,209	2,248	22,020	103,477		103,477		103,477			12
13	Nurse Aide Training											13
14	Program Transportation			3,629	3,629		3,629		3,629			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,161,002	45,182	88,588	1,294,772		1,294,772		1,294,772			16
	C. General Administration											
17	Administrative	75,032		209,784	284,816		284,816		284,816			17
18	Directors Fees											18
19	Professional Services			41,352	41,352		41,352		41,352			19
20	Dues, Fees, Subscriptions & Promotions			19,557	19,557		19,557	(638)	18,919			20
21	Clerical & General Office Expenses	66,175	17,902	15,013	99,090		99,090		99,090			21
22	Employee Benefits & Payroll Taxes			361,001	361,001		361,001		361,001			22
23	Inservice Training & Education											23
24	Travel and Seminar			9,690	9,690		9,690	(3,886)	5,804			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			121,344	121,344		121,344		121,344			26
27	Other (specify):*											27
28	**TOTAL General Administration**	141,207	17,902	777,741	936,850		936,850	(4,524)	932,326			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,809,609	378,843	1,031,585	3,220,037		3,220,037	(4,524)	3,215,513			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Holy Family Villa #0036186 Report Period Beginning: 7/1/99 Ending: 6/30/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			147,888	147,888		147,888	(13,869)	134,019			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,576	2,576		2,576	(2,576)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			6,116	6,116		6,116		6,116			35
36	Other (specify):*											36
37	**TOTAL Ownership**			156,580	156,580		156,580	(16,445)	140,135			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		1,390		1,390		1,390		1,390			41
42	Provider Participation Fee			54,352	54,352		54,352		54,352			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		1,390	54,352	55,742		55,742		55,742			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,809,609	380,233	1,242,517	3,432,359		3,432,359	(20,969)	3,411,390			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Holy Family Villa # 0036186 Report Period Beginning: 7/1/99 Ending: 6/30/00

VI. ADJUSTMENT DETAIL **A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	2,576	L32,C3		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	638	L20,C3		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 3,214		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 3,214		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

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Holy Family Villa

ID# 0036186

Report Period Beginning: 7/1/99

Ending: 6/30/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49				49
50				50
51				51
52				52
53				53
54				54
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56				56
57				57
58				58
59				59
60				60
61				61
62				62
63				63
64				64
65				65
66				66
67				67
68				68
69				69
70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	0		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Holy Family Villa # 0036186 **Report Period Beginning:** 7/1/99 **Ending:** 6/30/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Holy Family Villa** **#** **0036186** **Report Period Beginning:** **7/1/99** **Ending:** **6/30/00**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	0	0	0	0	0	0	0	0	0	0	0	0	45

Facility Name & ID Number Holy Family Villa # 0036186 Report Period Beginning: 7/1/99 Ending: 6/30/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
	N/A					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Holy Family Villa # 0036186 Report Period Beginning: 7/1/99 Ending: 6/30/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2	N/A										2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Holy Family Villa # 0036186 Report Period Beginning: 7/1/99 Ending: 6/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Catholic Charities
Street Address: 721 N. LaSalle St.
City / State / Zip Code: Chicago, IL 60610
Phone Number: (312-6557494
Fax Number: (312-9441550

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2	L17,C3	Administrative, Accounting and	Allocated based on	1	1	209,784	209,784	1	209,784	2
3		Data Processing Services of	time spent							3
4		Employees of Catholic Charities								4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 209,784	$ 209,784		$ 209,784	25

Facility Name & ID Number Holy Family Villa # 0036186 Report Period Beginning: 7/1/99 Ending: 6/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Lanier Business Systems		X	Purchase of Copier	$804.71	10/21/95	$ 9,804	$ 763	9/21/00	0.2191	$ 543	1
2	Ford Credit		X	Truck	$697.33	8/14/99	21,309	14,965	7/14/02	0.1075	2,033	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$1,502.04		$ 31,113	$ 15,728			$ 2,576	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 31,113	$ 15,728			$ 2,576	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Holy Family Villa # 0036186 **Report Period Beginning:** 7/1/99 **Ending:** 6/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1995	8
	1996	9
	1997	10
	1998	11
	1999	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Holy Family Villa # 0036186 Report Period Beginning: 7/1/99 Ending: 6/30/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 59,540 B. General Construction Type: Exterior Brick Frame Concrete Steel Number of Stories 2

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1		IDPA Adjustment		$ 2,000	1
2					2
3	TOTALS			$ 2,000	3

Facility Name & ID Number Holy Family Villa # 0036186 Report Period Beginning: 7/1/99 Ending: 6/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	48		1947	1947	$ 425,228	$		$	$	$	4
5			1951	1951	36,941	16,647	50	16,647		835,408	5
6	51		1957	1957	500,000						6
7											7
8											8
	Improvement Type**										
9	Windows Replaced			1978	96,000						9
10	Tuckpointing/Major Room Renovations/Underground Electric			1972	235,856						10
11	Electrical			1976	2,643						11
12	Bathrooms/Fire Door/Paving			1977	89,594						12
13	Electrical			1978	58,294						13
14	Electrical/Plumbing/Painting/Tuckpointing			1980	52,089						14
15	Electrical/Boiler Repairs			1981	12,113						15
16	Electrical/Plumbing/Boiler			1982	27,939						16
17	Paving/Electrical/Plumbing			1983	38,850						17
18	Roofing/Landscaping/Electrical			1984	52,997						18
19	Boiler/Electrical			1985	59,911						19
20	Windows/Electrical			1986	24,586	62,120	5-15 yrs.	62,120		1,090,498	20
21	Electrical/Plumbing			1988	21,323						21
22	Fire Alarm			1989	5,950						22
23	Tuckpointing/General			1990	41,351						23
24	Roofing			1991	30,521						24
25	Elevator/Water Softners/Painting/Electrical			1992	43,315						25
26	Security System/Generator/Removal Gas Tank			1993	78,036						26
27	Roofing/Soffits/Septic System/Furance			1994	44,312						27
28	Boiler/Hot Water System/Electrical Upgrades			1995	76,314						28
29	Window Curtains/Valances			1996	11,596						29
30	Heating System			1996	41,638						30
31	Stained Glass Window			1996	5,000						31
32	Pump			1996	4,798						32
33	Electrical			1996	18,546						33
34	Carpeting			1996	2,183						34
35	Water Softners			1997	7,708						35
36	TOTAL (lines 4 thru 35)				$ 2,145,632	$ 78,767		$ 78,767	$	$ 1,925,906	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Holy Family Villa # 0036186 Report Period Beginning: 7/1/99 Ending: 6/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Electrical			1997	21,880						9
10	Boiler			1997	35,412						10
11	Radiators			1997	14,300						11
12	Drapes/Carpeting			1997	9,163						12
13	Plumbing/Electrical			1997	24,934						13
14	Drapes/Carpeting			1998	12,210						14
15	Air Conditioning			1998	2,897						15
16	Nurses Call Systems			1998	7,500						16
17	Paving			1998	24,458						17
18	Electrical Pump			1999	2,042						18
19	Artwork/Water Meters/Boiler Work			2000	6,906						19
20	Sidewalk/Landscaping			2000	6,014						20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 167,716	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Holy Family Villa # 0036186 Report Period Beginning: 7/1/99 Ending: 6/30/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 312,392	$ 42,461	$ 42,461	$	5-10 yrs	$ 159,844	37
38	Current Year Purchases	24,215	1,234	1,234		5-10 yrs	1,234	38
39	Fully Depreciated Assets	388,605					388,605	39
40								40
41	TOTALS	$ 725,212	$ 43,695	$ 43,695	$		$ 549,683	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Resident Services	Fully Depreciated	Various	$ 108,634	$	$	$		$ 108,634	42
43	Resident Services	1999 Bus	1999	44,631	8,926	8,926		5 yrs.	13,389	43
44	Resident Services	Ford Pickup	2000	26,308	2,631	2,631		5 yrs.	2,631	44
45										45
46	TOTALS			$ 179,573	$ 11,557	$ 11,557	$		$ 124,654	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$	3,220,133	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$	134,019	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$	134,019	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$		50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$	2,600,243	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	Farm House & Rectory	$ 102,831	$ 1,947	$ 92,540	52
53	Rectory/House - 1997	123,759	8,251	28,878	53
54	Rectory Renovation - 1998	43,736	3,200	8,000	54
55	Rectory Improvements - 1999	2,355	471	707	55
56					56
57	TOTALS	$ 272,681	$ 13,869	$ 130,125	57

G. Construction-in-Progress

	Description	Cost	
58	Legal/Surveys/Architects/	$ 2,612,832	58
59	Engineers/Construction		59
60	(New Facility)		60
61		$ 2,612,832	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Patient Care	2000 Ford Van	$ 463.00	$ 1,852	17
18	Patient Care	1998 Ford Van	533.00	4,264	18
19					19
20					20
21	TOTAL		$ 996.00	$ 6,116	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Holy Family Villa # 0036186 Report Period Beginning: 7/1/99 Ending: 6/30/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	N/A	hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Holy Family Villa # 0036186 **Report Period Beginning:** 7/1/99 **Ending:** 6/30/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 308,359	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 25,000)	350,123		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	6,537		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 665,019	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	4,789		11
12	Long-Term Investments			12
13	Land	2,000		13
14	Buildings, at Historical Cost	1,066,999		14
15	Leasehold Improvements, at Historical Cost	1,519,029		15
16	Equipment, at Historical Cost	904,785		16
17	Accumulated Depreciation (book methods)	(2,730,368)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	273,300		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Construction in Progress	2,612,832		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,653,366	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,318,385	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 101,323	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	163,265		28
29	Short-Term Notes Payable	7,837		29
30	Accrued Salaries Payable	27,576		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 300,001	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	7,891		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Deferred Revenue - Chapel	273,300		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 281,191	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 581,192	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,737,193	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,318,385	$	48

***(See instructions.)**

Facility Name & ID Number Holy Family Villa # 0036186 Report Period Beginning: 7/1/99 Ending: 6/30/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,250,035	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,250,035	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	487,158	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 487,158	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,737,193	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Holy Family Villa # 0036186 Report Period Beginning: 7/1/99 Ending: 6/30/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,724,767	1
2	Discounts and Allowances for all Levels	(841,019)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,883,748	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	2,360	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,360	23
	D. Non-Operating Revenue		
24	Contributions	3,018	24
25	Interest and Other Investment Income***	30,391	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 33,409	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,919,517	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	988,415	31
32	Health Care	1,294,772	32
33	General Administration	936,850	33
	B. Capital Expense		
34	Ownership	156,580	34
	C. Ancillary Expense		
35	Special Cost Centers	1,390	35
36	Provider Participation Fee	54,352	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,432,359	40
41	**Income before Income Taxes (line 30 minus line 40)****	487,158	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 487,158	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Holy Family Villa # 0036186 Report Period Beginning: 7/1/99 Ending: 6/30/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,000	2,100	$ 49,750	$ 23.69	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,720	10,149	183,321	18.06	3
4	Licensed Practical Nurses	10,280	10,753	162,521	15.11	4
5	Nurse Aides & Orderlies	57,822	59,126	532,938	9.01	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,050	1,128	11,413	10.12	8
9	Activity Director	1,980	2,080	31,620	15.20	9
10	Activity Assistants	4,903	5,062	39,880	7.88	10
11	Social Service Workers	5,864	6,255	79,209	12.66	11
12	Dietician					12
13	Food Service Supervisor	2,000	2,080	37,053	17.81	13
14	Head Cook	5,950	6,250	62,049	9.93	14
15	Cook Helpers/Assistants	13,720	14,158	94,498	6.67	15
16	Dishwashers					16
17	Maintenance Workers	7,060	7,525	92,777	12.33	17
18	Housekeepers	17,865	18,773	150,697	8.03	18
19	Laundry	9,982	10,524	70,326	6.68	19
20	Administrator	2,200	2,400	75,032	31.26	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,000	2,200	36,200	16.45	23
24	Clerical	3,582	3,842	29,975	7.80	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,980	2,080	33,300	16.01	31
32	Other Health Care(specify)					32
33	Other(specify) Care Plans	1,980	2,080	37,050	17.81	33
34	TOTAL (lines 1 - 33)	161,938	168,565	$ 1,809,609 *	$ 10.74	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director		7,200	L9, C3	36
37	Medical Records Consultant		3,984	L10, C3	37
38	Nurse Consultant		500	L10, C3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		3,240	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 14,924		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	177	$ 7,854	L10, C3	50
51	Licensed Practical Nurses	83	2,846	L10, C3	51
52	Nurse Aides	1,188	24,309	L10, C3	52
53	TOTAL (lines 50 - 52)	1,448	$ 35,009		53

Facility Name & ID Number Holy Family Villa # 0036186 Report Period Beginning: 7/1/99 Ending: 6/30/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Roberta Magurany	Administrator	N/A	$ 75,032
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 75,032

B. Administrative - Other

Description	Amount
Support Services (Schedule VIII)	$ 209,784
TOTAL (agree to Schedule V, line 17, col. 3)	$ 209,784
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Deloitte & Touche	Audit Fees	$ 12,000
William H. Brower, P.C.	Accounting	2,350
ADP	Payroll Processing	9,137
Achieve Software	Comp. Consultant	2,602
Scantron	Comp. Consultant	1,494
REC Computer	Comp. Consultant	550
Integrity	Comp. Consultant	7,849
Catholic Charities	Insurance Consulting	3,753
Ed McKernin	Comp. Consultant	1,147
John Clark/IL Police	Background Checks	470
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 41,352

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 97,166
Unemployment Compensation Insurance	4,031
FICA Taxes	128,128
Employee Health Insurance	49,419
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension Expense	60,781
Staff Goodwill	21,476
TOTAL (agree to Schedule V, line 22, col.8)	$ 361,001

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	11,309
Health Care Worker Background Check	
(Indicate # of checks performed)	
Other Advertising	638
Dues and Subscriptions	7,610
Less: Public Relations Expense	( )
Non-allowable advertising	(638)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,919

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
Out of Town Travel/Seminars	3,886
In-State Travel	
Seminar Expense	5,804
Disallowed Out of Town Travel	(3,886)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,804

**See instructions.

Facility Name & ID Number Holy Family Villa # 0036186 Report Period Beginning: 7/1/99 Ending: 6/30/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2	N/A												
3													
4													
5													
6													
7													
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9													
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17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Holy Family Villa **#** 0036186 **Report Period Beginning:** 7/1/99 **Ending:** 6/30/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Network ($4,090)**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 yrs.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **5,512** Line **L10,C2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **54,352**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name and ID: Holy Family Villa #00360186

Period: 7/1/99 - 6/30/00

Support for page 21, Item G - Seminar Expense

	Providor	Seminar Description	Amount	Attended By	Location
Jul-99	Life Services Network	Interpreting Q.I. Reports	150	DON, MDS	Illinois
Jul-99	Life Services Network	Federal Survey Process	95	DON	Illinois
Sep-99	Illinois Activity Professionals	Activities Annual Conference	735	Activity Director	Illinois
Dec-99	Life Services Network	Administrator Continuing Ed.	395	Administrator	Illinois
Nov-99	Life Services Network	The Survey and Beyond	899	DON	Illinois
Mar-00	CES Alliance	Nutrition Conference	1,138	Food Service, and Administrator	Illinois
Dec-99	Life Services Network	OBRA Seminar	110	Administrator	Illinois
Apr-00	Life Services Network	Annual Spring Conference	1,342	Admin/Dept. Heads	Illinois
Sep-99	Life Services Network	Fall Institute	180	Administrator	Illinois
Nov-99	I.N.H.A.A.	Nursing Home Admin. Conference	760	Administrator	Illinois
		Totals	5,804		

Facility Name and ID#: Holy Family Villa #0036186

Period: 7/1/99-6/30/00

Listing Of Board of Directors (None provide services directly to Home)

Rev. John Kuzinskas - Chairman
Holy Family Villa
12375 McCarthy Road
Lemont, IL 60439

Jura Scharf - President
CAC
400 North May, Suite 304
Chicago, IL 60622

Fr. Anthony Puchenski - Vice. Chair.
7399 W. 159th Street
Tinley Park, IL 60477

Sr. Jean Girzaitis - Secretary
Sisters of St. Casmir
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Roberta Magurany - Asst. Sec.
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Chicago, IL 60608

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Promotion Specialists
6131 W. 129th Place
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Catholic Charities
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Chicago, IL 60661

Thomas Labanauskas - Director
13420 S. Potawatomi
Lockport, IL 60441

Mr. Vytenis Lietuvninkas
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